DIVISION OF MEDICAL SERVICES
PROVIDER BULLETIN

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PROVIDER BASED RURAL HEALTH CLINIC (RHC) BULLETIN

CONTENTS

CLARIFICATION OF BILLABLE RHC VISITS

Rural Health Clinic (RHC) visits between RHC patients and RHC core practitioners (physician, nurse practitioner, nurse midwife, physician assistant, licensed clinical social worker, or clinical psychologist) must include a medically necessary evaluation and management service in order to be reimbursed at the RHC rate. When a face-to-face encounter with a core service practitioner does not occur or when patients present to the clinic for a routine non-covered service, such as a blood pressure check, follow-up reading of a TB skin test, venipuncture, etc., an RHC visit may not be billed. An RHC visit is billable only for services provided in the clinic, in the patient's home or in a nursing home.

RHCs are entitled to their costs associated with Medicaid services. These costs include expenses incurred for services, such as injections, when a visit cannot be billed. The costs for such services are to be included in the RHC cost report.

Medical records must clearly document a medically necessary evaluation and management service when an RHC visit is billed. Billed visits that are not medically necessary are subject to recoupment by the Program Integrity Unit, Division of Medical Services (DMS).

VACCINES FOR CHILDREN (VFC) BILLING

Provider-based Rural Health Clinics (RHCs) may bill an appropriate level Evaluation and Management (E & M) code when a Vaccines for Children (VFC) immunization is provided if a medically necessary evaluation and management service is provided in addition to the VFC immunization. An administration fee may not be billed in addition to the RHC visit.

If a VFC immunization is identified as being medically necessary during an RHC visit but cannot be administered at that time, an office visit may not be billed when the patient returns for the immunization if the immunization is the only service provided. Include the costs associated with the immunization on the provider-based cost report.

If it is medically necessary to re-examine the patient when the patient returns for the immunization, an office visit may be billed. Medical records must document medical necessity and the service(s) provided.

MULTIPLE VISITS

Visits with more than one health professional and multiple visits with the same health professional which take place on the same day and at a single location constitute a single visit, except when one of the following conditions exist:

(a) After the first encounter, the patient suffers illness or injury requiring additional diagnosis or treatment.
(b) The patient has a medical visit and a psychiatrist, clinical psychologist or clinical social worker visit.

If it becomes necessary to provide additional services on the same date which constitute a separate visit, a *Certificate of Medical Necessity Form* must be completed and attached to the claim form. When filing through the DMS Internet Web service, www.emomed.com, the clinic may complete the on-line version of the medical necessity form using the "Add Header Medical Necessity" link. **Note – Both visits must be billed on the same claim form.**

SURGERIES/ PROCEDURES PERFORMED IN THE HOSPITAL SETTING

Providers were notified in February 2001 that the Centers for Medicare and Medicaid Services (CMS) had issued a Medicaid Bulletin to clarify that services provided by Rural Health Clinic (RHC) practitioners in the hospital setting are outside of the RHC benefit. This includes services provided in all types of hospital settings, such as inpatient, outpatient, and the emergency room. Surgeries/procedures performed in the hospital setting must be billed with the practitioner's private practice provider number or as performing provider of a non-RHC clinic/group. Payment will be made through the fee-for-service fee schedule.

Information on the Medicaid provider enrollment process and criteria is available on the Division of Medical Services Web site at www.dss.mo.gov/dms under the "Provider" link. If

you have further questions regarding the enrollment process, you may contact the Provider Enrollment Unit via e-mail at providerenrollment@dss.mo.gov.

GLOBAL OB/GYN SERVICES

Prenatal care must be billed as individual visits. If the patient delivers in the hospital, the delivery must be billed with the appropriate *Current Procedural Terminology* (CPT) code with the practitioner's private practice provider number or as performing provider of a non-RHC clinic/group. Payment will be made through the fee-for-service fee schedule. When a delivery and postpartum procedure code is billed, a visit may not be billed. Routine postpartum care for the mother within six weeks after delivery is included in the Medicaid reimbursement for the delivery. When a different practitioner has performed and billed for the delivery without postpartum care, the postpartum care only procedure code may be billed.

POSTOPERATIVE CARE

Surgeries/procedures performed in the hospital setting must be billed with the practitioner's private practice provider number or as performing provider of a non-RHC clinic/group. Payment will be made through the fee-for-service fee schedule. Postoperative care includes 30 days of routine follow-up care for those surgeries/procedures having a Medicaid reimbursement amount of $75.00 or more. Refer to section 13.41 of the Physician Manual for additional information regarding postoperative care.

Provider Bulletins are available on the DMS Web site at http://dss.mo.gov/dms/providers/pages/bulletins.htm. Bulletins will remain on the Provider Bulletins page only until incorporated into the provider manuals as appropriate, then moved to the Archived Bulletin paage.

Missouri Medicaid News: Providers and other interested parties are urged to go to the DMS Web site at http://dss.missouri.gov/dms/global/pages/mednewssubscribe.htm to subscribe to the electronic mailing list to receive automatic notifications of provider bulletins, provider manual updates, and other official Missouri Medicaid communications via e-mail.

MC+ Managed Care: The information contained in this bulletin applies to coverage for:

- MC+ Fee-for-Service
- Medicaid Fee-for-Service
- Services not included in MC+ Managed Care

Questions regarding MC+ Managed Care benefits should be directed to the patient's MC+ Managed Care health plan. Before delivering a service, please check the patient's eligibility status by swiping the red MC+ card or by calling the Interactive Voice Response (IVR) System at 573-635-8908 and using Option One.

Provider Communications Hotline
573-751-2896